3. The trend is toward providing more medical services for employees—through first aid on minor illnesses and, perhaps, through medical plans or similar plans for the more severe illnesses.

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COMPULSORY HOSPITALIZATION OF RECALCITRANT TUBERCULOUS PATIENTS*

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ULTIMATE CONTROL OF TUBERCULOSIS.—The ultimate control of tuberculosis rests on three factors:

1. Find the persons affected with the disease, particularly those who excrete bacilli. The great accent of today's tuberculosis campaign is upon this factor. Early diagnosis campaigns, x-ray surveys of the apparently well, follow-up of contacts, special attention to certain racial, industrial, and age groups, school surveys with investigation of the families of reactors, are some phases of this effort. Here the voluntary associations and official agencies work in close coöperation. With the advent of the small x-ray film and increased federal participation, such as examination of Selective Service men, and the establishment of a Tuberculosis Bureau in the United States Public Health Service, case finding has felt a tremendous upsurge the last one or two years, and bids fair to become very extensive as time goes on.

2. Hospitalize those patients who need it. This phase has seen increasing governmental participation at all levels. The care of the tuberculous is now accepted as a necessary function of tax-supported institutions. Such tremendous strides in this field have been taken during the past twenty years that the bulk of the building may be considered as accomplished, except for certain corners of the country. Whether we can agree or not with Doctor Drolet's paradoxical hypothesis that collapse therapy does not affect the death rate, there is no disagreement as to the value of the sanatorium as a place of isolation. Without sanatorium beds in which to put communicable tuberculosis the value of case finding would be lessened materially.

3. Establish the legal power to make it possible to bring suspected persons in for examination and to compel isolation, if communicable tuberculosis can be demonstrated, when the patient is unwilling to take the necessary steps voluntarily. This function, which is entirely a governmental one, has not been widely practiced. As a rule the tuberculosis programs have been directed toward those who willingly came for examination and hospitalization, while those whom urging and explanations failed to win over have been spared the penalty of compulsion. The era of generalized tuberculinization of the population has long passed. It used to be that for every person who was persuaded or compelled to enter a sanatorium there would be several other spreaders left in the population to keep the chain of tuberculous infection unbroken. Today, when in many states and counties there are adequate beds for all who need them, the uncontrolled known spreader calls for action.

ON EXTENT OF COÖPERATION

The vast majority of the tuberculous are cooperative. The incorrigible form a small per cent of the total. The problem does not loom large on the basis of their proportionate number of incorrigibles, but upon their magnified potential for harm to the community. If they are out of an institution, they are characterized mainly by their wilful commingling with the community and by failure to take precautions at home. In the institutions they become disciplinary problems, refuse to take the rest cure, upset the other patients, and usually leave without consent. The handling of this group, in or out of the sanatorium, is a strain upon the kindest doctors and nurses. From the standpoint of public health, it is the extramural patient group which is the most important, and most of the remainder will be extramural for significant periods, since going home without consent is a characteristic of the group.

THE INCORRIGIBLES

Who are the incorrigibles? They are persons suffering from active tuberculosis, whose sputum is grossly positive, who, after many warnings and attempts at hospitalization, continue to conduct themselves in such a manner as to endanger their families and their community. What makes them incorrigible? Certainly not the tuberculous infection. Most of the incorrigibles would be problem men and women even if they did not have tuberculosis. Some are chronic alcoholics—the variety that drifts in and out of local jails, and in and out of state mental hospitals. A significant portion is comprised of borderline psychotics—not insane enough to convince a jury that they are commitable to a state institution, but sufficiently unbalanced to be antisocial and difficult to handle. A few are narcotic addicts or ex-addicts. Some of the incorrigibility is due to simple ignorance and fear. A few are average individuals who have accepted hospitalization, and, finding it not to their liking, decide to make such a nuisance of themselves that, in self-defense and to maintain the morale of his institution, the medical director is compelled to expel them.

Our social service friends urge us not to forget that each of the recalcitrant tuberculous is, first of all, a human being, and, further, a wretched human being, who is reacting understandably to a difficult situation. For these reasons, they urge us to approach the patient as tactfully and kindly as possible. I am sure that, in the vast majority of cases, physicians, nurses, public health officers, social workers, ministers, and understanding relatives, all have exausted the usual considerate means of approach. The difficult patient who will react favorably toward decent treatment and adequate explanation is not incorrigible. It is only when

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these means have been found ineffectual that the problem calls for other than the humane approach. It has been truly said that one difficult patient can cause more headache to a health officer or to a sanatorium director than the collective problem of several dozen coöperative patients.

Granting, then, that all customary methods have been tried to bring the patient into line and have failed, what legal machinery can be invoked to cope with this menace to public health?

We naturally turn to the State Health and Safety Code as the final legal authority for all the powers of health officials, and we find there, under Section 2554, this regulation:

> Each health officer and coroner knowing or having reason to believe that any case of—and here are listed thirty-four communicable diseases, including tuberculosis—or any other contagious or infectious disease exists or has recently existed within the territory under his jurisdiction, shall take such measures as may be necessary to prevent the spread of the disease.

COMMENT

I leave to Mr. Martin, who will discuss this subject from the standpoint of a lawyer, elaboration upon the powers thus given to the health officer; but I emphasize here that they include the orders of isolation served upon tuberculous individuals.

In another section of the Health and Safety Code, similar powers are given to the State Department of Health, which may step into a jurisdiction, when the local authority neglects or cannot perform its function, and enforce similar powers. So we find that both the local health officer and the State health officer have this power; but, from a practical standpoint, it is hardly ever used by the latter, and is reserved for emergencies, as, for example, a plague epidemic, when the local jurisdiction could not handle the situation.

Most health officers are aware of their power in this matter. They feel the need of the power in connection with the recalcitrant tuberculous and would like to bring them to bar. However, in some counties they have been unable to convince the district attorneys. Sometimes the district attorneys will point to the section giving the State health officer that power and ask for an order from the State before legal action is begun. However, such orders have not been forthcoming for the reason given above. Some district attorneys, and, it must be said, some health officers, too, feel that they cannot act as directly in a chronic disease like tuberculosis as in an acute disease like smallpox, and fear that public opinion would not be behind them. It is a fact that in most of the counties of this State there has never been a single order of isolation issued against a tuberculous person, and, therefore, for the officials of those counties it would be a step in a new and untried field fraught with unanticipated developments. Obviously, the health officers cannot go far without the coöperation of the district attorneys if penalties are to be imposed for the breaking of isolation.

EXPERIENCES IN LOS ANGELES COUNTY

The extensive and enduring experience of Los Angeles County indicates that only a small fraction of those upon whom orders of isolation are served need ever be taken to court. The majority obey the orders. Even the jail sentence does not in fact turn out to be as cruel as it sounds, since the majority of those sentenced are paroled to the sanatorium and are sent to jail only if they again break isolation. Doctor Telford will be able to tell us more of the details in his discussion. It would seem highly desirable for other counties to follow the aggressive and successful methods of Los Angeles County.

Three weeks ago a meeting was held in Los Angeles to debate the topic now under discussion. Sanatorium physicians, health officers, social workers, and others, were invited to participate. Many phases of the matter were roundly thrashed out. Some of the constructive suggestions made are incorporated in the remaining paragraphs of this paper.

Granting that we have the problem, that it is a big problem, and that we have the machinery to handle it, there remains the task of fitting this machinery to an individual patient. Degrees of communicability are varied, the various personal problems of the recalcitrants are many, and the number and quality of available beds in which to isolate them differ widely from county to county. It may be truthfully said that some counties cannot, by virtue of their special situations, handle the matter as other counties do. Mono County, with 1,400 people, scattered over a wide area, and no beds for tuberculosis, cannot do the same as San Francisco County.

SOME GENERAL PRINCIPLES

However, there are certain generalizations which hold for all counties, and to help make the isolation of the incorrigible more effective and more easy, the following proposals have been made:

First, the regulations of the State Department of Health regarding communicable disease should be strengthened in regard to tuberculosis. This has been done by Doctor Wynns, State Epidemiologist, who recently revised the regulations for all communicable diseases, and in the new version which was recently adopted by the State Board of Health the following phrase is added to the section on tuberculosis:

> Patients afflicted with tuberculosis in a communicable stage who refuse to observe the health officers' instructions and thereby expose others needlessly to infection shall be placed in quarantine; and in the event that such quarantine proves inadequate for the protection of members of the household or the community the patient shall be placed in isolation in quarters designated by the local health officer until such time as such quarantine or isolation is no longer necessary for the protection of the public.

This regulation is very specific and provides for either quarantine or isolation. It also makes the local health officer the deciding authority in the matter, which is as it should be.

Parenthetically, it may be agreed that quarantine has little or no place in the control of tuberculosis. Isolation is the necessary method. In the above regulation, quarantine is mentioned first for the sake of completeness, and, second, because the

Health and Safety Code stresses the word "quarantine." Property is quarantined, of course, but persons are isolated.

A *second* method of improving the situation would be to convince those health officers who do not believe so, that they have this power of isolating the tuberculous. There are some who, if reassured as to their power, would not hesitate to use it. There is, too, a group of health officers who know they have the power, but hesitate to apply it. Some of the reasons are intimately bound up with the feeling tone of other officials of the county.

Thirdly, the district attorneys about the State must be shown that when the health officer wishes to bring a case before the court on the charge of breaking isolation he must be supported legally by them. We have now a clear statement from representatives of the Attorney-General's Office that, under these circumstances, it is the duty of the district attorney properly to prepare the case and to prosecute the recalcitrant before the court.

The health officer must remember that the burden of proof is upon him to establish the communicability of the patient. He must have a "good case." It goes without saying, to begin with, that since action is usually considered only in the most obvious cases there should be no difficulty in making an acceptable brief. On his side the attorney must prepare the case adequately.

The usual criterion of communicability is a "grossly positive" sputum. This is taken by most to mean bacillus demonstration by an *unconcentrated* smear of the sputum. But this is not the only criterion. A large cavity might lead into a temporarily blocked bronchus, which would result in a temporarily negative sputum. Or evidently active disease might be present in a patient who would bring in someone else's sputum. The health officer should utilize additional methods and verify his opinion, and gastric lavage is one way of getting the sputum from the right individual. The Health and Safety Code provides power of examining persons "suspected" of having a communicable disease. Again the district attorney's insistence is necessary in the bringing of a recalcitrant to examination.

A *fourth* suggestion which is attractive to many is the creation of a State sanatorium which would be reserved for certain special categories of patients. Even if we did not have the incorrigible to deal with, we would still need a State sanatorium for patients who have State but not county residence, for patients who are nonresidents awaiting return or are not returnable to their home communities, and for patients coming from the smallest counties which have no tuberculosis bed facilities at all. Such a State institution could also have a locked ward to which judges could sentence the incorrigible tuberculous. This would do away with the disadvantage of keeping isolation breakers in a small prison in close contact with other prisoners. It would save the morale of institutions to which otherwise such a patient would be sent, and where he would have a demoralizing effect. Further, the very existence of such an institution, when known generally throughout the State, would act as a deterrent to the would-be incorrigible. Sometimes, as has been brought out by others, judges hesitate to send patients to tuberculosis facilities which are of unsatisfactory grade. The type of medical care in this proposed State institution could be of such high quality that there would be no question as to the advisability of sending a patient there.

Fifthly, all institutions for the care of the tuberculous should immediately report the identity and status of communicability of every discharged case to the local health officer. This is especially important when several counties are served by one sanatorium.

Lastly, as has been emphasized by everyone who has written or spoken of this problem, we must intensify our campaign of educating the public in regard to the dangers of tuberculosis. A certain amount of soft-pedaling has come into our publicity to take the horror-story coloring from tuberculosis; but no amount of softening can hide the fact that it is a disagreeable and deadly disease, and that those who wilfully expose others to it are as guilty of a breach in human conduct as those who poison food or kill by more violent means. The public must be told the danger in plain words. Here the voluntary associations, with able use of publicity media, can help a great deal. When the menace of the occasional uncoöperative and defiant vectors of infection is sufficiently emphasized, an aroused public opinion will demand the effectual control of such individuals.

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ONE of the most important of all health regulations is that directed to the exclusion of communicable diseases and the keeping of such diseases, when they once gain an entrance, within the smallest possible limits and providing for the establishment and enforcement of regulations by which their general dissemination shall be prevented and their continued existence rendered improbable or impossible. Power to make quarantine regulations is one of the most frequent powers conferred upon boards of health. The authority of health officers or boards of health to quarantine for scarlet fever, diphtheria, smallpox, measles, and other such common maladies, is so well recognized, both as a practical measure and by judicial endorsement, that any comment concerning such authority would be superfluous. However, it appears that no definite steps have been taken with respect to the quarantine of those infected with

* From the office of the Attorney-General, State of California.

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